cedures distributed by HCFA was scuttled, but at press time HCFA was at work on a revised list to apply January 1.

When HCFA originally proposed the Medicare fee schedule last June, SNM and ACNP joined the American Medical Association (AMA) and other medical societies in protest of the proposal. The plan would have yielded payments 16% lower than current Medicare spending—spending cuts that physicians groups said were not intended by Congress. To the further dismay of doctors, HCFA proposed a "behavioral offset" to compensate for increases in volume of services the Administration anticipated physicians would make in response to the new fee schedule. Nuclear medicine physicians say they particularly resent the behavioral offset, since they depend on referrals from other physicians. In drafting the revised fee schedule, HCFA considered more than 95,000 comments and the pressure of Congress, where two bills that would enforce changes in the Medicare rule gained widespread support.

In the final rule, Medicare payments for family practice physician and generalists services increase relative to the fees for most specialty services including diagnostic imaging. HCFA says that after volume increases are factored in, total Medicare spending will be the same as if the new fee schedule were never adopted. The behavioral offset, however, was retained in the final rule and increased from 3% to 6.5%. In addition, a volume performance standard calls for cuts in future reimbursements if spending in a given year exceeds a predetermined amount.

With the publication of the final rule, AMA leaders said they intended to work with HCFA to deal with the "fundamental problems" that persist in the revised fee schedule. AMA Executive Vice-President James S. Todd, MD said that the AMA hopes to "move forward now in a much more cooperative fashion" to refine the Medicare system, in prepared comments suggesting that the AMA hoped to diffuse the rancor that had developed between HCFA and organized medicine over Medicare reimbursement. Dr. Todd added that the AMA would continue to press Congress to achieve an "equitable implementation" of the RBRVS that the legislators mandated in 1989.

SNM and ACNP leaders anticipate continued cooperation with other medical societies in dealings with HCFA. In discussions at the RBRVS strategy meeting, working with the AMA and the American College of Radiology emerged as a goal of SNM President Leon S. Malmud, MD and ACNP President Terrance Beven, MD. Both presidents acknowledged the importance of further ACNP and SNM cooperation. Emphasizing the increasing role of government in medical practice, Dr. Malmud said, "It's critical to work together even more closely to protect our patients by ensuring the availability of our services for diagnosis and treatment of illness." ■

Major Changes in the Nuclear Cardiovascular Codes

Advances in cardiovascular nuclear medicine technology in the past two years—including the commercial introduction of new technetium-99m (^{99m}Tc) imaging agents and the availability of intravenous drugs used for pharmacologic stress tests—have changed dramatically the state-of-the-art in cardiovascular medicine. These changes in clinical practice necessitate changes in the existing CPT reporting codes. (Physicians, imaging centers, and hospital outpatient departments use the CPT coding system for billing most insurers, including Medicare. The American Medical Association (AMA) administers the CPT code, which is revised annually.

A working group representing nuclear medicine and cardiology recommended—and the AMA CPT Editorial Panel adopted—major changes to the cardiovascular system section of the CPT codes for nuclear medicine. These substantial changes will require many changes in physicians' reporting procedures. New and revised CPT codes take effect on January 1, the day Medicare begins transition to a new fee schedule based on a resource based relative value scale (RBRVS).

Nuclear medicine physicians and cardiologists who perform cardiovascular nuclear medicine tests quickly recognized the coding problems resulting from the advances in clinical cardiovascular nuclear medicine. The Society of Nuclear Medicine (SNM), the American College of Cardiology (ACC), the American College of Radiology (ACR), and others worked together early in 1991 to develop a joint recommendation for new and revised codes and descriptors to submit to the AMA's CPT Editorial Panel. AMA coding staff assisted with the deliberations of the working group.

As a result of this collaboration—essentially comprising the entire professional community performing cardiovascular nuclear medicine procedures—the CPT panel adopted all but one of the recommended changes. (The panel declined to adopt a new code for the gated SPECT scan, although the procedure is well established.) What follows is a summary of the new and revised codes:

Improved Hardware and Software

Imaging cameras and computer hardware and software packages that support cardiovascular nuclear medicine procedures now offer a wide range of quantitative measures derived from perfusion and functional studies. The output from the software includes phase and amplitude analysis, regurgitant index, volume determinations, regional ejection

fraction, and cardiac output. Because these quantitative measures do not require significantly more resources than the qualitative studies from which these measures are derived, discrete codes for several specific quantitative measures have been deleted for 1992 and others have been modified to include quantitative measurement. (The modified codes include 78466 for myocardial infarct imaging, 78472 and 78473 for cardiac blood pool gated equilibrium, and 78483 for cardiac blood pool first-pass technique. The deleted codes include 78415 for phase and amplitude analysis, 78425 for regurgitant index, and 78467 for quantitative myocardial infarct imaging.)

Intravenous Agents for Stress Tests

Cardiologists are using intravenous agents such as dipyridamole (I.V. Persantine/DuPont Merck) as pharmacologic alternatives to exercise for cardiovascular stress testing. To accommodate the new technology, the descriptors for all procedures that involve cardiovascular stress (78460, 78461,78464, 78465, 78473, 78483, and 93015) have been expanded for 1992 to cover "exercise and/or pharmacologic" methods for producing cardiovascular "stress." The hybrid word "and/or" signifies that these codes are intended to cover circumstances when pharmacologic stress is combined with exercise and when pharmacologic stress is performed alone.

New ^{99m}Tc Agents

The Food and Drug Administration (FDA) at the end of 1990 approved for marketing two new agents used for myocardial perfusion imaging and functional evaluation: ^{99m}Tc sestamibi (Cardiolite/DuPont Merck) and ^{99m}Tc teberoxime (Cardiotec/Squibb Diagnostics). These agents are alternatives to thallium-201 (^{201}Tl) for perfusion imaging, but the two new agents possess vastly different physical and pharmacokinetic properties from ^{201}Tl and from each other.

Because of the unique features of each radiopharmaceutical, new testing protocols for the combination, order, and spacing of rest and stress images have been developed. These protocols differ from those used for ^{201}Tl. To detect and localize areas of ischemic myocardium and to differentiate these areas from scar tissue, a single injection of ^{201}Tl can be given with stress-rest images obtained on a single day (typically four hours apart). With ^{99m}Tc sestamibi, however, two injections are used and either stress-rest or rest-stress images are obtained (on a single day or over a two-day period.)

To accommodate these changes in medical practice, the myocardial perfusion imaging codes (planar or SPECT imaging methods/codes 7846×) have been revised for 1992 to distinguish a single study (e.g. rest alone or stress alone) from multiple studies (e.g. stress-rest, rest-stress, or rest-redistribution). The previous codes were inadequate because they specified only rest or stress-rest protocols. The procedure codes for multiple studies cover examinations performed on one or more days and involving one or more injections of a radiopharmaceutical. Parallel changes also have been made to the codes for cardiac blood pool gated-equilibrium studies (7847×) and cardiac blood pool first-pass technique studies (7848×).

In addition to perfusion imaging, with ^{99m}Tc sestamibi, first-pass functional studies to assess wall motion or ejection fraction can be combined with perfusion imaging following a single injection of the radiopharmaceutical. To report the performance of these combined procedures, the 1992 edition of the CPT manual has added two new codes. The code number 78478 covers a myocardial perfusion study with wall motion, and 78480 covers a myocardial perfusion study with ejection fraction. These new codes are "secondary procedure" codes to be used only in combination with the perfusion imaging "primary procedure" codes (78460-61 for planar images and 78464-65 for SPECT imaging). These new codes are to be listed separately on claim forms; they are not code modifiers. Previously there was no clear mechanism for providers to bill for the combination of perfusion imaging and first-pass functional testing when performed following a single injection of a radiopharmaceutical.

In addition to the changes summarized above, several other adjustments make the code descriptors internally consistent. For example, the descriptor for the myocardial infarct imaging code 78468 was changed from "with emission computed tomography" to "tomographic (SPECT) with or without quantitation" to conform to other code references to SPECT procedures.

Many payers provide separate payment for radiopharmaceuticals (under CPT 78990 for diagnostic radionuclides) and for the drug used to produce pharmacologic stress (under CPT 99070, or J3490 for Medicare). Consult local payers for the proper coding for these pharmaceuticals.

If problems are encountered early in the year, check with local payers to be sure that they have incorporated the new codes and descriptors into their claims processing system.

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